

Georgia Department of Community Health
Hospital Advisory Committee Meeting
April 19, 2007

The meeting was called to order at 1 p.m. Committee members attending were:

HOSPITAL	MEMBER/DESIGNEE
Central Georgia Health System	Rhonda Perry, co-chair
Ty Cobb Healthcare System	Chuck Adams, co-chair
Children's Healthcare of Atlanta	David Tatum
East Georgia Regional Medical Center	Robert Bigley
Grady Health System	Timothy Jefferson
Piedmont Healthcare	Timothy Stack
Satilla Regional Medical Center	Katrina Wheeler
St. Joseph's / Candler	Paul Hinchey
Tift Regional Medical Center	William Richardson
Upson Regional Medical Center	Gene Wright
Wellstar Health System	Marsha Burke

In opening remarks, Carie Summers, Chief Financial Officer, conveyed the Department's appreciation to committee members for their willingness to serve. Regarding the role of the advisory committee, Ms. Summers presented the following:

- The primary purpose of the Hospital Advisory Committee is to provide guidance to the Department regarding proposals for Medicaid/PeachCare payment rates and other policy issues. Committee members are asked to seek fair and equitable solutions that are in the best interests of the patients being served, recognizing that such solutions may not always match the interests of an individual hospital.
- As reconstituted, the number of committee members was reduced from 21 to 13 members. Dr. Rhonda Medows, the Department's Commissioner, named Rhonda Perry and Chuck Adams to serve as committee co-chairs.
- The most immediate issue for consideration by the advisory committee will be DSH funding.
- Other issues that may require committee review include considering of changes that may result from proposed federal changes regarding use of intergovernmental transfers for matching funds and possible cost limitations on governmental providers.

In addition to DSH funding issues, information was also presented regarding the Department's planned update to DRG rates used in payments for inpatient services. Ms. Summers explained that the Department would follow legislative intent that DRG rates be revised to utilize a more current DRG grouper, with appropriate revisions to DRG base rates and relative weights. While information about the update process had been presented to the preceding advisory committee, the Department presented a review of the Department's planned approach. The Department then planned to review more detailed information at the committee meeting scheduled for May 3, during which committee members would be asked for recommendations about proceeding. Yvonne Powell, from EP&P/Navigant Consulting, then explained the process by which updated

DRG rates were being developed (a copy of Ms. Powell's presentation is attached and included as a part of these minutes.) She explained that no policy or payment rule changes would be made as a part of the update process, but the main focus would be the use of a more current DRG grouper and more recent cost data. Ms. Powell presented budget neutrality alternatives that had been reviewed with the DRG work group appointed by the preceding advisory committee, and she asked that committee members contact the Department if there were other alternatives that should be considered; co-chair Chuck Adams asked that an option that combined limitations on capital and peer group cost coverage be added to the list of alternatives. In subsequent discussions, committee members agreed that a DRG work group should again be appointed to allow for a more detailed review of the DRG update process. The new DRG work group would include representatives from the preceding group as well as additional members representing hospitals newly appointed to the advisory committee, with members to be appointed by the committee co-chairs.

As a beginning point for DSH discussions, Jim Erickson and Kevin Londeen explained the process by which data elements used for DSH funding are subject to validation (a copy of the detailed presentation made by Mr. Erickson is attached and included as a part of these minutes.) In summary comments, Mr. Londeen observed that any significant errors in data would be likely to trigger either desk reviews or onsite visits, so the resulting data should provide a reasonable basis for DSH funding. Ms. Summers noted that the DSH data collection and validation processes follow the recommendations made by the preceding advisory committee and its work group on DSH data matters. Ms. Summers also asked committee members to contact her if they should have any subsequent questions regarding the reliability of DSH data.

In a brief discussion regarding future meeting subjects, IGT funding was identified as a topic of interest. The meeting was then adjourned.

Navigant Consulting, Inc.

Overview of Inpatient Hospital Rebasing



April 19, 2007

Overview



Section 1 » Overview of Rebasing Process



Section 2 » Changes to System from Rebasing

- Peer Group Rates
- Relative Rates
- Outlier Thresholds
- Add-on Amount (*capital, GME*)



Section 3 » Payment Impact of Rebased System



Section 4 » Budget Neutrality Options

Overview of Rebasing Process



Basic DRG payment components:

1. Use of a “Grouper” to classify individual claim based on the type of claim

2. Once classified into appropriate DRG:

- (a) Peer group per case rate (Operating cost)

Multiplied by

DRG-specific Relative Weight

- (b) Add-on for capital and GME

Overview of Rebasing Process (cont.)



Sample claim payment -- current vs. new system

<i>Sample Claim Payment Under Current Payment System</i>							
DRG V16	Covered Charge	Current Outlier Threshold	Current Base Rate	Current Relative Weight	Operating Payment	Current Add- ons	Current System Payment
370	\$6,856.70	\$28,516.24	\$3,737.81	1.2246	\$4,577.32	\$230.17	\$4,807.49
<i>Sample Claim Under New Payment System</i>							
DRG V23	Covered Charge	New Outlier Threshold	New Base Rate	New Relative Weight	Operating Payment	New Add- ons	New System Payment
370	\$6,856.70	\$33,172.20	\$5,096.13	0.9466	\$4,824.00	\$410.29	\$5,234.29

Overview of Rebasing Process



Five key components updated in developing new payment rates (*data used to this point in rebasing work*):

1. New Grouper (*v16 versus v23*)
2. Paid claims data: SFYs 2004 and 2005*
3. Cost-to-charge ratios: HFYs 2003 and 2004
4. Capital add-on: HFY 2004 cost reports and capital surveys for CY 2004 and 2005
5. GME add-on: 2004 cost reports

* *All non-Medicare claims were included, both CMO and FFS*

Changes to System from Rebasing



- Several changes in the DRG groups occur as a result of moving from Grouper *v16* to Grouper *v23*. Preliminary findings from last fall:
 - 41 new DRGs (*v23*) created from 54 old DRGs (*v16*)
 - 111 combinations of old and new DRGs

- Changes in Outlier Thresholds

Changes to System from Rebasing (cont.)



➤ Changes in Peer Group Base Rates

Two factors contribute to the change in base rates

1. As a result of the changes in the outlier thresholds, a larger percentage of the claims are paid as “inliers”.
2. Changes in relative weights

➤ Capital and GME add-on amounts under the rebased system

Payment Impact of Rebased System



- In our preliminary work, maintaining reimbursement at a level that is budget neutral has built on two adjustments:
 - When setting the new rates, costs across hospitals were inflated to a common point of time that is prior to the midpoint of the new payment year (*costs were all inflated to January 1, 2005*)
 - The overall level of payment across all rate components (*base rates and/or add-on components*) needs to be reduced to reflect that the rebased payment level exceeds budget neutrality

Payment Impact of Rebased System (cont.)



Sample claim payment -- current vs. new system

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Budget Neutrality Options



- Initial budget neutrality scenarios considered:
 1. Capital add-on capped at 10% or a statewide average increase; remainder of reduction uniform across all peer group base rates
 2. Uniform budget neutrality adjustment across all peer group base rates; no adjustment to capital component
 3. Peer group-specific budget neutrality adjustments
 4. Statewide budget neutrality goal achieved through peer group-specific budget neutrality adjustments to bring each peer group to equal cost coverage

Budget Neutrality Options



Discussion of next steps



Myers and Stauffer_{LC}

Certified Public Accountants

2007 Georgia DSH Survey and Validation

Survey Form

- Survey was developed to gather data not readily available from another source:
 - Out-of State Data
 - “Other” Medicaid Eligible Days
 - Cash Subsidies for Patient Services
 - Charges and Payments for the “Uninsured”
 - Calculation of Net Hospital Revenue
 - Medicaid Cost-to-Charge Ratio

Survey Form

- Utilized the same survey as 2006 with some enhancements:
 - FAQ's were addressed in the instructions
 - HS&R Summary worksheet added
 - Out-of-State I/P & O/P Charges/Payments separated
 - Section G – Medicaid CCR added

Desk Review Process

- Submitted surveys imported into database
- Data was analytically reviewed
- Selection criteria were developed to select providers for further review
- 66 out of 152 (43%) were selected for desk review

Desk Review Selection

- 1) Percentage of “Other” Medicaid eligible days to Total I/P days $> 5\%$
- 2) Difference between O/S payments as a % of charges and GA Medicaid payments as a % of Charges $> 15\%$ with at least \$50,000 in O/S charges

Desk Review Selection (Cont)

- 3) % of Uninsured Payments to Charges at hospital compared to industry average.
 - a) Industry avg. was 5.7%
 - b) If hospitals collection differed by $> 5\%$ they were selected
- 4) Change in '07 Uninsured Charges from '06 Charges was greater than 15% and \$1M

Desk Review Selection (Cont)

- 5) If uninsured charges as % of total charges increased from '06 to '07 by greater than 1%.
- Selected hospitals were sent a request letter for documentation of selected items
 - Review procedures were performed on data to determine if adjustments are necessary

Adjustment Areas (Desk)

- Survey not in agreement with documentation
- Professional fees were included
- Service dates outside of cost report period
- Duplicate claims in claim's summary
- SSI days were used for "other" eligible days

Desk Review Adjustment Results

“Other” Eligible Days

As-Filed	41,434
Adjustment	(24,077)
Allowed	17,357
Error Rate	(58.11%)

Desk Review Adjustment Results

I/P Uninsured Charges

As-Filed	300,272,761
Adjustment	(13,843,691)
Allowed	286,429,070
Error Rate	(4.61%)

Desk Review Adjustment Results

I/P Uninsured Payments

As-Filed	9,604,632
Adjustment	(1,308,382)
Allowed	8,296,250
Error Rate	(13.62%)

Desk Review Adjustment Results

O/P Uninsured Charges

As-Filed	353,640,442
Adjustment	(6,730,689)
Allowed	346,909,753
Error Rate	(1.90%)

Desk Review Adjustment Results

O/P Uninsured Payments

As-Filed	22,865,152
Adjustment	(1,344,136)
Allowed	21,521,016
Error Rate	(5.88%)

On-Site Reviews

- Performed after the desk reviews, and after preliminary DSH calculations were performed
- In total 15 hospitals were selected for further verification through an on-site review

Criteria for On-Site Selection

- Facilities were separated into the various DSH eligibility categories
- Facilities with large changes in their estimated DSH payments from '06 to '07 within the eligibility categories were selected

Criteria for On-Site Selection

- Facilities with large changes in their facility specific DSH limit from '06 to '07
 - Changes in Medicaid Shortfall/Longfall
 - Changes in net Costs of the Uninsured

Adjustment Areas (On-Site)

- 1) Survey did not agree to documentation
- 2) Service dates outside of reporting period
- 3) Claims related to another facility were on the hospitals claim summary
- 4) SSI days used to support “other” eligible days

Adjustment Areas (On-Site)

- 5) Professional fees were noted in the patient claim detail
- 6) Claims related to prisoners were noted in the claim detail
- 7) Claims related to babies covered under mothers insurance were identified

Adjustment Areas (On-Site)

- 8) Claims with actual commercial insurance or 3rd party coverage were identified
- 9) Additional payments were noted in patient file detail that were not on survey
- 10) CCR's or Per Diems on Section G did not agree to C/R

Adjustment Areas (On-Site)

- 11) Charges in Section G did not agree to the HS&R that was supplied
- 12) Reported grouping of charges did not properly match charges to expenses

On-Site Review Adjustment Results

“Other” Eligible Days

As-Filed	19,125
Adjustment	(3,208)
Allowed	15,917
Error Rate	(16.77%)

On-Site Review Adjustment Results

I/P Uninsured Charges

As-Filed	371,575,932
Adjustment	(11,862,091)
Allowed	359,713,841
Error Rate	(3.19%)

On-Site Review Adjustment Results

I/P Uninsured Payments

As-Filed	5,364,480
Adjustment	(1,800,851)
Allowed	3,563,629
Error Rate	(33.57%)

On-Site Review Adjustment Results

O/P Uninsured Charges

As-Filed	361,858,708
Adjustment	(9,950,338)
Allowed	351,908,370
Error Rate	(2.75%)

On-Site Review Adjustment Results

O/P Uninsured Payments

As-Filed	15,603,708
Adjustment	(2,372,737)
Allowed	13,231,010
Error Rate	(15.21%)

Summary Adjustment Results

- 36 of the 66 (55%) facilities subject to Desk procedures were adjusted
- 13 of the 15 (87%) facilities subject to On-Site procedures were adjusted